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ABSTRACT

A therapeutic technique for dealing with a chronic caller to a suicide prevention center was tested. The two objectives to such a technique were to reduce the frequency of calls made by chronic callers to the suicide prevention service, and to persuade callers to be more specific when discussing their problem. To accomplish these objectives, a specific counselor was assigned to each chronic caller, with a one hour time limit to each call, and the suicide prevention center called the chronic caller instead of waiting for the chronic caller to contact the service. Results of the seven-week treatment program indicated that prior to instituting the change, the mean number of calls made per week for the treatment and control group were roughly equal. Upon completion of the program, the mean number of calls per week for treatment callers was significantly lower than those chronic callers who were not in the treatment group. This trend in the data was maintained during a nine-week follow-up condition. Self-report measures obtained from the counselors indicated that the chronic callers were becoming more concrete and specific when presenting their particular problem. Suggestions regarding the manner in which other community mental health centers might implement a similar program were discussed. (Author/PC)

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THERAPEUTIC MANAGEMENT OF CHRONIC CALLERS TO A SUICIDE PREVENTION CENTER

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In the United States there are approximately 200 suicide prevention and crisis intervention services in operation. These services consist of 24-hour crisis hotlines manned by part-time volunteer paraprofessionals. These counselors are often required to enroll in an intensive training program designed to equip the counselors with the skills necessary to help individuals who are experiencing some sort of personal crisis.

Very often a suicide prevention service will encounter individuals who call quite regularly. This type of caller has been labeled the "chronic caller". A chronic caller can be operationally defined as one who calls the service as often as five times a day for a period of one month or longer (Lester & Brockopp, 1970).

The chronic caller poses a number of problems to a suicide prevention service. First, many of these services only have three or four hotlines in operation. When these phones are tied up by chronic callers, it becomes quite difficult to talk with first-time callers. A second problem created by the chronic caller is that only rarely will he or she call with a specific problem. It is often believed that chronic callers usually do not possess suicidal tendencies and instead are calling the service merely to "ventilate their feelings" (Lester & Brockoop, 1970).

The Suicide Prevention and Crisis Service of Columbus, Ohio is currently receiving calls from 14 chronic callers, as well as many other first-time callers. Many of these chronic callers have been contacting this particular service for over two years. Previous techniques, used by the service in Columbus, for dealing with this type of caller have included setting a pre-determined time limit for the duration of the caller's conversation and,keeping a list of chronic callers and then having the staff formulate a plan for working with each individual caller. Although both of these methods elicited initial success in reducing the number of

calls, long-term maintenance of this reduction was not observed.

Other approaches for treating the chronic caller have been proposed by Brockoop (1970). These approaches include (a) having the chronic caller write to the service rather than call, (b) group therapy sessions with a number of chronic callers and, (c) having the service call the chronic caller instead of waiting for this type of caller to contact the service. Because of the limitations on budget, time allotment, and available staff, group therapy sessions with a number of chronic callers would no doubt prove to be a cumbersome method for many community mental health centers to implement. Having the chronic caller write to the service and then respond back to the caller in writing, seems to be a rather impersonal and time consuming approach.

One method that would appear to be a promising alternative approach for working with the chronic caller would consist of having the suicide prevention service call the chronic caller instead of waiting for the chronic caller to contact the service. None of the studies to date have evaluated what effect this method would have on the frequency of calls made by chronic callers to a suicide prevention service.

The purpose of this study was to assess whether calls placed to chronic callers, by the suicide prevention service, would have an effect in reducing the frequency of calls made by chronic callers to the service. Two additional forms of treatment, namely, assigning a specific counselor to each chronic caller and, requiring a one hour time limit with respect to each call, were also assessed. The rationale for the two adjunctive forms of treatment was to persuade the chronic callers to become more concrete and systematic when discussing their particular problem.

Method

Subjects

Fourteen chronic callers (6 males, 8 females) who contact the Suicide Prevention

and Crisis Service in Columbus, Ohio, were employed in this study. The caller's ages ranged from 18 to 63 years, with a mean age of 32 years. Seven chronic callers, chosen at random, served in the treatment group and the remaining seven comprised the control group. Seven of the twenty counselors who were employed at this service were chosen at random for the purpose of calling the chronic callers.

Procedure

Even before the onset of this study, it was common practice for the service in Columbus to keep strict records regarding the number of times a chronic caller would call the service each day. Each time a chronic caller would call, the counselor who accepted the call would place a tally mark next to that caller's name in a log book located next to each crisis hotline. These records were kept in strict confidence, and were available only to those counselors directly involved with the suicide prevention service. This procedure was kept constant throughout the duration of the study. The first four weeks of this procedure were used to assess the mean number of calls made per week by each subject in both the treatment and control group. This four week interval comprised the baseline condition.

During the seven week treatment condition, each of the seven counselors were required to call his or her designated chronic caller once a week, the same day each week. The counselors were also required to record the following information immediately following each call: the date the call was made, whether or not the chronic caller was specific in discussing his or her particular problem, and the overall effectiveness of the call.

At the time of initial contact with the chronic caller, each counselor explained the format of the weekly calls and, in addition, told the chronic caller that the weekly calls from the service did not preclude their calling the service whenever they felt the need. The seven chronic callers in the control group

were not contacted by any of the counselors, nor were they told that other callers were being contacted by the service.

It was hypothesized that the mean number of calls made by the treatment group, during the baseline condition, should be significantly greater than their mean number of calls made during the treatment condition. The mean number of calls made by the control group during baseline should not be significantly different than during the treatment condition. It was also hypothesized that the mean number of calls for the treatment group should be significantly less than that of the control group, upon the completion of the treatment condition.

Results and Discussion

From Table 1 it may be seen that the mean number of calls made by the treatment group during baseline was 24.28, as compared to 23.92 for the control group. The mean number of calls for the treatment group during the treatment condition was 12.42, as compared to 22.14 for the controls.

The follow-up condition indicated that the reduction in calls made by the treatment group, from baseline to treatment, was maintained nine weeks after the calls from the service had been terminated. Mean number of calls made by the control group for baseline and treatment conditions (23.92 and 22.14, respectively) were approximately equal to the number of calls made by this group during follow-up (21.42).

Insert Table 1 About Here

An analysis of variance for the data of Table 1 indicated that the main effect of time period on the number of calls was statistically reliable, but neither the effect of the treatment group, nor the interaction between weeks and treatment were reliable. However, since the trend in the data was consistent with the prediction of an interaction between weeks and treatment group, a test of simple main effects for an SPF-2.3 design was employed (Kirk, 1968).

Table 1

Mean number of calls made per week by each chronic caller for baseline, treatment, and follow-up conditions.

		Baseline	Treatment	Follow-up
Treatment Group	S_1	16.00	12.00	15.00
	S_2	19.00	16.00	17.00
	S_3	38.50	21.00	16.00
	S_4	24.50	10.00	10.00
	S_5	16.00	12.00	8.00
	S6	17.00	7.00	8.00
	S_7	39.00	9.00	6.00
	$\overline{X}$	24.28	12.42	11.42
Control Group	S_1	60.50	52.00	50.00
	S_2	42.50	25.00	17.00
	S_3	14.50	27.00	30.00
	S_4	22.00	10.00	9.00
	S_5	13.00	21.00	23.00
	S_6	9.00	10.00	9.00
	S_7	6.00	10.00	12.00
	$\overline{X}$	23.92	22.14	21.42

As can be seen from Table 2, the number of calls made by the control group for baseline, treatment, and follow-up conditions did not significantly differ from one another ($F[2,24] F < 1.0$, ns). However, the simple main effects analysis does indicate, as was predicted, that the mean number of calls made by the treatment group for the treatment and follow-up conditions, does differ significantly from its mean number of calls made during baseline ($F[2,24] = 7.35$, $p < .01$).

Insert Table 2 About Here

By randomly assigning each chronic caller in the treatment group an individual counselor, it was hoped that this would serve as a catalyst in prompting the client to become more specific when discussing a particular problem. Information regarding chronic caller specificity was assessed via self-report measures from the seven counselors who had been calling the chronic callers. The results from these self-report measures did seem to indicate that the chronic callers were making an active effort to become more specific regarding the nature of their conversation. The counselors formulated their opinion regarding this improvement on such factors as to what extent the caller was setting realistic goals for himself, how often the caller would go off on irrelevant tangents during the conversation, and the overall effectiveness of the call.

An important issue to be discussed concerns what became of the chronic callers once they stopped calling the service. While a few continued to call the service, they cut down on the number of calls they made, thus removing themselves from the "chronic" category. Others took advantage of the community mental health services which their counselors referred them to, eliminating altogether their need to receive support from the suicide prevention service.

In reviewing the overall implications of this study, the following three recommendations can be made for community mental health centers which are faced with the problem of effectively dealing with the chronic caller: (1) have the suicide

Table 2

Analysis of Variance for Simple Effects

Source	df	SS	MS	F
Between Subjects				
Baseline	1	.45	.45	.001
Treatment	1	330.28	330.28	1.98
Follow-up	1	350.00	350.00	2.10
Within Cell	36	6005.70	166.80	
Within Subjects				
Weeks at Trt. Group	2	716.09	358.05	7.35*
Weeks at Control Group	2	23.21	11.60	.24
Weeks by Trt. Group	2	243.59	121.79	2.50
Weeks by Subject Within Groups	24	1169.56	48.73	
Total Variance	41	7182.10		

* p .01

prevention service call the chronic caller once a week and then gradually fade the number of calls which must be made, (2) set a one hour time limit with respect to each call and, (3) assign a specific counselor to each chronic caller. Whether or not all three of these proposals are necessary to help abate the frequency of calls from chronic callers, is a question that would call for the implementation of a component analysis in future research.

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